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PROVIDENCE Health & Services

Notice On Health Plan Disclosure Restriction Requests

This notice provides information about how Providence Health and Services may use and disclose your protected health information when a restriction on disclosures to your health plan has been requested.

- You have the right to request a restriction of disclosures of protected health information to your health plan.
- Providence is required to agree to a restriction regarding a health care service for which you have paid in full and out of pocket.
- You must submit payment in full for this restriction to be implemented. If payment is not received in full, this restriction will no longer be valid.
- In the case of combined services, we may or may not have the ability to separate the items or services. If we cannot separate the items or services, your health plan still may be able to determine that the restricted item or service was performed based on the context. If we are not able to separate a group of items or services, you will be informed and given the opportunity to restrict and pay out of pocket for the entire collection of items or services.
- This restriction is applicable only to the provider and visit listed below. If you want other providers to restrict this information, you must make the request directly to that provider. Other providers may include anesthesiology, laboratory, imaging, pathology, and/or other physician professional fees.
- This restriction will not apply to subsequent but related treatment encounters, such as follow-up care for treatment of a particular condition. If you want information restricted at future visits, you must make a new request.
- Previously restricted information may be disclosed to the health plan if required for follow up billing unless you request an additional restriction and pay out of pocket for the follow-up care. For example, if you receive follow up care for a diagnosis identified by a lab test that you requested to be restricted, the lab test may be released if required to pay for the follow up treatment. You would have to request a separate restriction of the follow up care visit(s) and pay out of pocket for that care to eliminate the possibility of the lab result being released to the insurance company.
- Visit information restricted from being sent to your insurance company will still be sent to your Primary Care Physician and will be viewable by other clinicians who provide you care.
- This request will not affect disclosures required by law, treatment, or healthcare operations.
- If you wish to revoke this request for restriction, please send a note requesting a revocation that includes your name, date of birth and address to:

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PROVIDENCE Health & Services

DO NOT BILL INSURANCE RESTRICTION REQUEST

Last Name: First Name: MI:

Other Name(s) Used: DOB:

Address:

City: State: Zip: Phone:

For what State:

☐ Alaska ☐ California ☐ Montana ☐ Oregon ☐ Washington

I am requesting restriction of disclosure on records from the following location(s):

Hospital	Clinic

I hereby request that Providence not disclose my protected health information, including all treatment, payment, or health care operations, regarding the listed service date to the health plan(s) described below:

☐ For the date of:

☐ Health Plan(s):

☐ Information pertaining to:

By signing this form I acknowledge receipt of the **Notice on Health Plan Disclosure Restriction Requests**. This notice provides information about how Providence may use and disclose my protected health information when a restriction on disclosures to my health plan has been requested.

Signature: _____ Date:

Signature of Patient or Personal Representative

If personal representative signs this request on behalf of the patient, complete the following:

Print Name:

Relationship to Patient: ☐ Power of Attorney for Healthcare* ☐ Legal guardian*

☐ Parent ☐ Other

*Attach legal documentation if you are the legal guardian or Power of Attorney for Health care

For Internal Use Only

Date Received:_____ Initials _____ MRN_____

Sent to: _____ Date: _____